AN ASSESSMENT OF THE QUALITY OF FAMILY PLANNING SERVICES RENDERED TO ADOLESCENTS BY HEALTH WORKERS AT MDANTSANE CLINICS, MDANTSANE, EASTERN CAPE PROVINCE, S.A.

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Mini-Dissertation submitted in partial fulfillment for the degree of Magister Curationis (Advanced Community Nursing Science)

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DECLARATION

I, Siphokazi Ndlebe, declare that this mini-dissertation is my own work. It is submitted for a Masters degree in Nursing at the University of Fort Hare, South Africa. It has not been submitted before for any degree or examination at this or other University.

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Candidate: S. Ndlebe                              Date:

The work presented in this mini-dissertation was undertaken in the School of Health Sciences,

Department of Nursing Sciences, University of Fort Hare, South Africa.
DEDICATION

Dedicated with love to:

My husband, Temba, and my children, Sinelizwi, Liyadala and Lisemi.
ABSTRACT

**Background:** Family planning services are rendered at no cost in all clinics in Mdantsane. Mdantsane is situated in the Eastern Cape and falls under Amathole District Municipality. The high rate of adolescent pregnancy in the area raises a question as to whether the family planning services are adequate. This issue reflects on the quality of family planning service delivery. According to Roux (1995:94), a quality service is a safe, easily available and readily acceptable service, delivered by well trained family planning personnel through well planned programmes.

**Aims and Objectives:** To assess the quality of family planning service delivery by health providers to adolescents; determine the opinions of adolescents regarding accessibility, friendliness of staff, privacy, confidentiality, reproductive health information and resources at Mdantsane clinics from June to July 2009.

**Method:** A questionnaire was designed to collect data. The questionnaire was administered on the adolescents utilizing the reproductive health services at eleven primary health clinics in Mdantsane. A sample consisting of 110 adolescent youth between 19 and 24 years was selected by using random sampling. A response of “yes” will indicate that the participant is satisfied with the specific item, while a response of “no” will indicate dissatisfaction with that item. A specially designed spreadsheet was developed to analyze the data. Data was analyzed by using the Microsoft Excel 2007 Version 6.

**Results:** The results from this research study suggest that there is a definite need for improvement of adolescent reproductive health services at Mdantsane clinics. It is clear that the current available maternal and child health programmes, school health services and reproductive health services are not able to meet the adolescent sexual and reproductive needs.

**Conclusion:** The research findings from this study indicated the constraints to good quality family planning health care service delivery. Satisfaction responses from the five categories: health facility amenities, accessibility, staff characteristics, availability of sexual and reproductive health services and availability of educational material accessibility were mostly below 70%. The responses regarding the question on the “full information about the available contraceptives”showed the least level of
satisfaction. Deficiencies in physical facilities and equipment, disruptions in supplies, insufficient information provided to clients and providers’ insensitivity to the feelings and needs of the clients are issues that discourage adolescents from utilizing contraceptive services.

**Recommendations:** Adolescents need a safe and supportive environment that offers information and skills to equip them on all aspects related to sexual and reproductive health issues. To satisfy adolescent reproductive needs, the following key elements should be improved: accessibility of reproductive health services, friendliness of clinic staff, availability of information about reproduction and sexuality and maintenance of issues regarding confidentiality and anonymity. Quality requires the presence of trained personnel in well-equipped clinics where clients are treated courteously. To avoid issues of courtesy bias, there is a need to conduct a similar survey utilizing alternative community settings, namely homes of participants or a school.
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NOMENCLATURE

Adolescence

Acquired immunodeficiency syndrome

Contraceptive services

Eastern Cape Department of Health

Human Immunodeficiency Virus

Mdantsane Clinics

Quality contraceptive service delivery

Reproductive Health Care Services

Youth – Friendly Sexual and Reproductive Health Services
CHAPTER ONE: INTRODUCTION

1.1 Background of the study

According to the South African Demographic and Health Survey (1998) the Department of Health is the principal provider of contraception, providing over 90% of modern methods that are rendered at no cost in all primary health care clinics. Primary health care principles ensure that services are effective, available, efficient, sustainable and affordable for all South Africans, regardless of income, race, and gender. Despite all this, the adolescent pregnancy rate continues to rise at Mdantsane Township. According to the South African Demographic and Health Survey (1998), in the Eastern Cape, teenage pregnancy increased by 14% in 2003. The increase in pregnancy rate therefore needs urgent attention and remedy because it causes a burden on the economy of the country as more money is allocated for child support grants. This also leads to a great number of school drop-outs whereby an adolescent will have to look after the baby.

According to Moloney-Kitts, Fuchs, Brown, Conly & Delay (2003:19) prevention of unintended pregnancy and HIV transmission can be achieved through dual protection. One of the most effective ways to prevent unintended pregnancy and Human immunodeficiency virus (HIV) infection is for mutually monogamous, uninfected partners to practice effective contraception. Other dual protection methods are: the practice of abstinence and or delay of sexual debut, correct and consistent condom use, and the use of an effective family planning method along with correct and consistent condom use (dual protection method).

Unprotected sex may lead to sexually transmitted infections (STIs), HIV infection and unintended pregnancies. During Voluntary Counselling and Testing (VCT), the risks of pregnancy should also be discussed during pretest counselling. Referral to family planning services and provision of non-clinical methods should be available for clients who want a family planning method.

The high adolescent pregnancy rate raises a question as to whether family planning service standards in Mdantsane are adequate. This issue reflects on the quality of family planning service delivery. According to Roux (1995: 94), a quality service is a safe, easily available and
readily acceptable service, delivered by well trained family planning personnel through well planned programmes. The effectiveness of such a service is largely dependent on education, counseling and information provided for the clients.

1.2 The Definition and Objective of a High Quality Program

According to Jain, Bruce & Mensch (2000: 94), high quality and low quality programmes contrast as much in content as in goals. The only standard for quality that can be articulated with confidence is a process standard that gives answers to the following question: What is a programme seeking to do for its clients? A programme of high quality is client oriented and aims to help individuals achieve their reproductive intentions and goals. Although its focus is not on demographic targets, a high quality programme would still have an impact on fertility reduction. Such a programme, however, will not implement fertility reduction policies that may come in direct conflict with its clients welfare. Nevertheless, improvement in the quality of care will reduce fertility by increasing contraceptive use.

1.3. Elements of Family Planning programme success

Roux (2002: 33-34) identified the following six elements of family planning success and these will be discussed as the basics that will improve quality of family planning services:

1.3.1 Contraceptive Security

To succeed, a family planning programme needs an uninterrupted supply of a variety of contraceptive methods that clients can choose from and use their preferred method without interruption. Successful programmes provide contraceptive security ensuring that people are able to choose, obtain, and use high quality contraceptives whenever they want them. Offering full range of contraceptive options is also important. Contraceptive security requires planning and commitment on several commodities, equipment and other supplies should be always available (Roux, 2002:33).

1.3.2 Client Centered Care

When clients receive services that are tailored to their needs, they are more likely to find a suitable method, continue to use it and return to a provider when they need help or another method. Client centered care means that clients’ needs guide the planning and implementation
of family planning services. It also means that services meet medical standards, which require provider’s commitments and expertise (Roux, 2002:33).

1.3.3 Easy Access

When clients can easily obtain services, they are better able to use family planning and to obtain help when they want it. In the broadest sense, a population has good access to services when service delivery points are conveniently available to everyone, and everyone knows where to find these services, everyone feels welcomed, services are free of unnecessary administrative and medical barriers, and people can choose from a range of contraceptives. Offering services through multi-channels, such as clinics, community based distribution, private practices, mobile or temporary facilities, and retail outlets, helps to increase access (Roux, 2002:33).

1.3.4 Affordable Services

As the number of contraceptive users increases worldwide, growth is fastest among those least able to pay for services. The decrease in donor funding for many programmes challenges these programmes to keep services affordable for everyone while ensuring that people are able to choose, obtain, and use high quality contraceptives whenever they want them. Targeting free or subsidized family planning services affordable for all clients should be considered. Affordable services also contribute to the financial sustainability of programmes (Roux, 2002:34).

1.3.5 Effective Communication

The highest quality, most accessible health care services are pointless if people do not know about them or want them. Effective behavior change communication activities raise awareness about family planning, motivate individuals to seek services, and help them to successfully use their contraceptive method of choice (Roux, 2002:34).
1.3.6. Trained Staff

According to the 2007 worldwide poll of nearly 500 health care professionals, a sufficient, well trained, supervised, and motivated staff is the most important element of success in family planning programmes. Good quality services require a strong human resource system, a supportive working environment, and motivated providers who are well trained in clinical procedures. Providers should also have up to date knowledge of contraceptive technology and good interpersonal communication skills (Roux, 2002:34).

1.4 Problem Statement

Adolescent pregnancy is increasing even though family planning services are available in all Mdantsane clinics. One wonders whether service delivery by health workers for adolescents is of good quality. Quality refers to both readiness and level of preparedness of facilities to offer services and the manner in which clients are cared for (Rama Rao & Mohana, 2003:63). Quality of family planning service delivery is questionable in terms of availability of information, education and communication with clients visiting family planning clinic. High provider workloads, staff shortages and inadequate specific training in health promotion significantly constrain the provision of effective client counselling and public health education. The specific information, education, communication needs of disadvantaged groups (adolescents) are neglected (National Contraception Policy Guidelines, 1999:13).

1.5 Research Questions

What are the opinions of adolescents regarding accessibility, friendliness of staff, privacy, confidentiality, reproductive health information, resources and the quality of reproductive health services rendered?

1.6 Aim of the study

The aim of the study is to assess the quality of family planning services being delivered by health providers to adolescents at Mdantsane clinics.
1.7 Research Objectives

To document the demographic characteristics (age, marital status and state of previous pregnancy) of the adolescents receiving family planning services at the primary health care facilities in Mdantsane clinics from January to August in 2009.

To explore and describe the availability of health facility amenities, accessibility of family planning services, staff characteristics, availability of sexual reproductive health services, educational material and the quality of reproductive health services rendered at Mdantsane clinics during June to July 2009.

1.8 Significance of the Study

The results of this study will contribute towards improvement of contraceptive policy guidelines. The findings of this study will provide information that will assist family planning health providers and policy makers to review their policy and guidelines.

1.9 Definition of Concept

Adolescents

Adolescents are young people ranging from 15-24 years who have undergone puberty but who have not reached full maturity (Free Online Dictionary).

Adolescent Sexuality

Adolescent Sexuality refers to sexual feelings and behaviour. The sexual behaviour of adolescents is in most cases influenced by cultural norms and mores, and their sexual orientation. Sexuality is a complex part of our personality that encompasses lifestyle and choices, intimate feelings, sexual reproduction but involves physical, psychological and social components (National Contraception Policy Guidelines, 1999: 36).

Contraception

Contraception is the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures (Stacy, 2009:22).
Emergency Contraception

Emergency Contraception is the prevention of pregnancy after unprotected vaginal intercourse. Drugs related to the female hormones called Estrogen and Progesterone are prescribed (Stacy, 2009:25).

Injectable Contraceptives

Nur-Isterate and Depo-Provera are contraceptive injections that contain the synthetic Progestin hormone which prevents ovulation (National Contraception Policy Guidelines, 1999:37).

Oral Contraceptives

Triphasil and Ovral are oral contraceptives that contain the synthetic progestin hormone which prevents ovulation (National Contraception Policy Guidelines, 1999:37).

Family Planning

Family planning refers to the ability of individuals and couples to decide on and attain their desired number of children and the spacing between births. It is achieved through contraception and the treatment of involuntary fertility (National Contraception Policy Guidelines, 1999:36).

Dual Protection

Dual protection is the use of any means to prevent both unwanted pregnancy and sexually transmitted infections and HIV infections. Abstinence, the use of condoms alone, and dual method use are all dual protection strategies (National Contraception Policy Guidelines, 1999:33).

Sexually Transmitted Infections

Sexually transmitted infections are infections affecting men and women that generally are transmitted during sexual activity. The infections usually cause discomfort. Some may lead to infertility and some may be life threatening (National Contraception Policy Guidelines, 1999: 36-37).
**Human Immuno Deficiency virus**

Human immune virus is the virus that lowers the immune system, thereby causing various opportunistic infections and diseases to attack the body (HIV/AIDS care and counseling study guide, 2002:9).

**Quality of Care**

Quality of care is the term used for the standard of service provided to contraceptive clients. Six fundamental elements for measuring the quality of care offered by contraceptive services are: choice of methods, information given to clients, technical competence of providers, interpersonal relations, mechanisms to encouraging continuity, and appropriate constellation of services (National Contraception Policy Guidelines, 1999:35).
CHAPTER TWO - LITERATURE REVIEW

2. INTRODUCTION

This chapter covers the following areas:

- Demographics of South African Youth
- Pregnancy rate among Adolescent Youth of the Eastern Cape and South Africa
- Developmental Characteristics of Adolescent Youth
- Prevalence of HIV and Sexually Transmitted Diseases among adolescents in the Eastern Cape and in South Africa
- Abortion Rate among adolescents in South Africa and in Eastern Cape
- Use of Contraceptives as a Method of Reducing Adolescent Pregnancy
- Factors Contributing to Under-utilization of Reproductive Health Services by Adolescents
- Condom Use by Adolescent Youth
- Quality Reproductive Health Care Delivery
- Initiatives to Improve Quality of Adolescent Reproductive Health Services
- Legislation and Health Policy on Adolescent Access to Contraceptive Services
- Characteristics of Youth Friendly Services
- Study Designs, Data Collection Methods, and Programmes used to assess Quality of Service Delivery
- Use of Observations and Exit Interviews for Measuring Quality of Reproductive Health Services
- A Rapid Assessment of Quality Reproductive Health Services, Strengths and Weaknesses of some Research Studies
2.1 Demographics of South African Youth.

According to Statistics South Africa (2005), youth aged 15 to 24 years constitute about 20% of the total population. Of the youth aged 18 years, 65.5% attend school while 2.8% are at university or university technikon and 2.4% are at technical college. General life expectancy at birth in 1999 was 63 years for males and 68 years for females, higher for Whites and lower for Blacks. The 1999 birth rate was 33 per 1000 and death rate was 7 per 1000. Infant mortality was 46 per 1000 live births.

Nicholas, Daniels and Hurwitz (2006:2) argued that South African societies have different cultural, religious beliefs and values pertaining sexuality. The controversy around formal sex education is predicted on the erroneous belief that instruction about sexuality will increase premarital sexual behaviour. When parents are considered as the ideal location for the dissemination of sex information, it is often overlooked that many children do not have both parents available to them, and that fathers have always had minimal involvement in the transmission of sex information in two parent families. In a survey of 2206 black South African students (Nicholas, 1994a), 16.3% of the respondents indicated that they did not use condoms during sexual intercourse because it was against their religion.

2.2 Pregnancy rate among Adolescent Youth of the Eastern Cape and South Africa

Adolescent pregnancy is high in South Africa, despite a relatively high reported contraceptive prevalence of 64.4% among 15 to 19 year old sexually active young women. A recent study of age specific fertility rates conducted in a rural area of South Africa, reported an atypical bimodal pattern of fertility with underlying modes of premarital fertility among women aged 28 to 30 years. Premarital fertility accounted for 47% of births among women of 12 to 26 years, and accounted for 21% of all births. In 2005, it was estimated that the pregnancy rate was 330 per 1000 women under the age of 19 years, and 40% of all pregnancies were estimated to be teenage girls. In 2003, teenagers accounted for 15% of births in South Africa and 22% of those aged 15 to 29 years were pregnant. Among rural school girls in the former Transkei, 23% of adolescents had previously been pregnant. Of women delivering at Butterworth Hospital, also in Transkei, 28% were aged 19 years and younger (Nicholas et al, 2006:24-25).
Results from research conducted by the South African Demographic and Health Survey (1998), revealed that teenage pregnancies commonly occur in women who are at school, and that teenage pregnancy is more prevalent in the following provinces: Mpumalanga (18.8%), Northern Cape (15.2%), Northern Province (14.9%) and Eastern Cape with 14.8%.

2.3 Developmental Characteristics of Adolescent Youth

According to the Policy Guidelines for Youth and Adolescent Health (2009:19), adolescent and youth are characterized by substantial physical, social and psychological changes. Physically, there are changes in body size and stamina, and the reproductive system matures to enable pregnancy and child birth to take place. Socially, new relationships develop, especially outside the family, and psychologically, the capacity for empathy and abstract thinking become manifest. These changes are accompanied by new opportunities. Decisions affecting their well being are increasingly taken by the young people themselves, many of which are related to developing a sense of identity.

There are two key implications in terms of adolescent and youth health policy development. First, many of the decisions and choices made in adolescence have an influence through the life span. An unwanted pregnancy can alter the life course of a young woman, especially if it results in her dropping out of school. The WHO (1998) estimated that 70% of premature deaths of adults are due to behavior initiated during adolescence. Second, a certain amount of risk taking is necessary for optimal development, risk taking has even been described as a vital tool that adolescents can use to shape their lives. The challenge for policy makers is thus to help young people find ways to use this vital tool to promote their health and well being whilst actively contributing to the collective project of social transformation and development (Policy Guidelines for Youth and Adolescent Health, 2009:19).
2.4 Prevalence of Human immunodeficiency virus (HIV) and Sexually Transmitted Infections among Adolescents in the Eastern Cape and in South Africa

In South Africa, sexually transmitted infections (STIs) constitute a major public health problem. The annual caseload seen only at state or municipal clinics and in private practice is estimated at more than a million patients in a population of 40 million. The most common STIs in South Africa, as well as in Eastern Cape, are syphilis, herpes, gonorrhea and nongonococcal urethritis. Secondary and post high-school students are at risk of acquiring STIs because they are mostly single and the highest incidence of infection occurs in people between the ages of 15 and 24 (Nicholas et al., 2009:26-27).

According to the 2008 Report on Global Aids Epidemic (UNAIDS, 2008), an estimated 1.9 million people were newly infected with HIV in Sub Saharan Africa in 2007. In total 22 million people are living with HIV in the region, which is two thirds (67%) of the global population of people with HIV. Most epidemics in Sub Saharan Africa appear to have stabilized but in South Africa the estimated 5.7 million South Africans living with HIV in 2007 represents the largest HIV epidemic in the world (UNAIDS Report on Global AIDS Epidemic, 2008).

Young women are particularly disadvantaged in the domain of sexual health. It is, for example difficult for them to obtain contraceptives, partly because of pejorative attitude towards sexually active young women. Lack of economic resources and physical power renders them vulnerable to sexual exploitation and increased risk of sexually transmitted infections such as HIV infection. In some communities, sexual relations with young girls are desired by some men since they are less likely to be HIV positive and sex with young girls may even be regarded as the cure for AIDS (Policy Guidelines for Youth and Adolescent Health, 2009:24).

2.5 Abortion Rate among adolescents in South Africa and in Eastern Cape

The Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996) has extended reproductive health services to women by providing for termination of pregnancy upon request. The Act defines a woman as a female of any age. Section 5 of the Act provides that termination
of pregnancy may only take place with the informed consent of the pregnant woman. It further provides that no consent other than that of the woman shall be required for the termination of pregnancy. Therefore any pregnant female of any age can consent to termination of pregnancy. Although the section requires a medical practitioner or midwife to advise a pregnant minor to consult with her parents, guardian, family members or friends before pregnancy can be terminated, the section makes it clear that termination of pregnancy shall not be denied because such minor chooses not to consult such persons (Policy Guidelines for Youth & Adolescent Health, 2009:15& 39).

It has been shown both internationally and in South Africa that unsafe abortions result in significant morbidity and mortality. Prior to the recent amendment of legislation governing the termination of pregnancy, it was suggested that between 6000 and 120000 illegal abortions were undertaken per annum in South Africa, most of which were young women. Even after the legislative amendment, the prevailing problem is that those who most need access to safe abortions are those who are least likely to reach present services. According to the Department of Health, within the first three months of the implementation of the Choice of Pregnancy Act, 60% of nearly 7300 terminations took place in Gauteng (Policy Guidelines for Youth & Adolescent Health, 2009:39).

2.6 Use of Contraceptives as a Method of Reducing Adolescent Pregnancy Rate

A Demographic and Health Survey conducted in 1999 by the Eastern Cape Department of Health, revealed that a considerable 18% prevalence in pregnancy rate amongst the age groups of 14 to 21 years existed (Eastern Cape Department of Health Demographic and Health Survey, 1999). Gaps in knowledge about the availability of contraceptive services and inaccessibility of such contraceptive services were identified. Results from this survey revealed that the Eastern Cape Department of Health does not provide regular information about sexual intercourse and birth control to teenagers. Furthermore, the government- sponsored sex education programmes in school systems are not supported. In addition, programmes on health teachings on contraceptive methods and easy access to contraceptive services are lacking (Demographic and Health Survey, 1999).
2.7 Condom Use by Adolescent Youth

According to the Policy Guidelines for Youth and Adolescent Health (2009:37), regarding condom use specifically, which is of relevance both for the prevention of unwanted pregnancy and sexually transmitted infections, such as HIV infection, it was found that significant numbers of young people have never used a condom during sexual intercourse. In some studies, over 90% of the girls or young women surveyed had never used one. Of those who have ever used a condom, a minority reported always using one. In studies which asked respondents whether they used a condom in their last sexual encounter, low rates were reported.

Teenage boys are not seen visiting family planning clinics and are reluctant to use condoms as a form of contraceptive and a method of infection control. The teenage boys refused to use condoms because they commented that sex with a condom was not enjoyable. In a study conducted by Mwaba in 2003 as cited in Mlambo (2005:65), teenage girls expressed a preference for receiving the injectable contraceptive and stated that condoms were not the birth control method of choice. According to the 1999 Demographic Survey Eastern Cape Province, among sexually active women who use any type of contraceptive, the use of condoms as the principal method is low. Only 2.3% of women reported using condoms, an equivalent of 16 women out of 712 sexually active women using contraceptives in the sample. Condoms offer double protection against pregnancy and sexually transmitted infections including HIV. In the 1999 survey, interviews conducted assessed whether there was privacy in the area where condoms were placed. Results indicated that only 41% of the clinics with condoms provide them in a private setting. In Ghana, Kenya, Tanzania and Zimbabwe, contraceptive use is high, but its use is low among adolescent males and females (Tawiah, 2002:81-82). These statistics must be read in the light of the fact that some clinics have only one room, so privacy is extremely difficult to maintain in many clinic settings (Demographic Survey Eastern Cape Province, 1999).
2.8 Factors Contributing to Under-utilization of Reproductive Health Services by Adolescents

Mmari and Magnani (2003:259), Williams, Schutt-Aine & Cuca (2000:20) and Senderowitz (2000:31) agree that young unmarried adults tend not to go to health facilities particularly public clinics for their reproductive needs. Traditionally, maternal and child health and family planning were designed to serve the child bearing and child spacing needs of married women. In some places, because of cultural sensitivities, services are withheld from young people, especially if they are unmarried. Furthermore, few providers have had any specialized training or gained experience in meeting the special needs of adolescents.

While health services and providers struggle to cope with limited resources and heavy demands, adolescents often lack faith in the services, especially if there is a shortage of medicines and the facilities are not clean and in a hygienic state. For HIV and AIDS, adolescents often do not access health services because of the stigma or for socio-cultural reasons (WHO, 2004).

Different factors contribute towards the unwillingness of adolescents to access reproductive health services (Fisher, Cruz, Eaton, Mukoma & Pillay, 1999:18). These factors include being embarrassed to be seen in a reproductive health facility, concern about a lack of privacy and confidentiality, or being afraid that their parents might find out about their visit. In addition, they are afraid of medical procedures, especially pelvic examinations. There is ignorance about the location of reproductive health services or unfamiliarity with the kind of services offered, lack of transportation to an existing clinic sites, staff hostility and being ashamed if others know that they have experienced coercive or abusive sex.

Haile, du Guerny and Stloukal (2000:15) argued that, in Africa, it is estimated that almost 30 million married women of reproductive age would like either to stop childbearing or space the birth of their next child, but cannot do so because they have no access to family planning services. The real unmet need for family planning may be even greater if one includes women who are not married, but are sexually active and wish to adopt a family planning method. Given the fact that the vast majority of the African population lives in rural areas and given that most urban areas are better supplied with family planning services, it is safe to assume that most family planning services in urban areas are better than those rendered to the rural population. This means that, although tradition and cultural beliefs are more prevalent in rural Africa than
in the cities, and information and services have not been made available to the rural population, millions of rural men and women nevertheless want to regulate their reproductive lives, but are unable to do so.

Mlambo (2005:67) stated that participants in his research study indicated that teenagers are reluctant to visit clinics for contraceptives as their anonymity is not guaranteed. A common concern is that the respondent cannot go to a family planning clinic because they may come across their relatives who may tell their mothers about their visit. In a study conducted by Dreyer in 1994 as cited in Mlambo (2005: 67), teenagers are often too shy to visit an adult family planning clinic. Transport remains a barrier to the accessibility of the health and youth centres. Most of the respondents reported that the health centre and the clinic are far from where they stay so they cannot afford transport to go there. Often contraceptives are provided, while sex education is neglected, because of the heavy workload of the staff. Some respondents stated that there is nothing explained to them, they just go through and are given an injection. The nurses always look busy and respondents were afraid to ask questions. According to Knott and Lotter (1999:580), as cited in (Mlambo, 2005:65), teenagers are afraid to make use of family planning services, are dissatisfied with the quality of communication at clinics, perceive the staff as being unapproachable. They want health care providers to be approachable, friendly and caring.

Teenage and adolescent pregnancy often results from lack of knowledge about the contraception. Girls who had been using the injectable contraceptive reported weight gain. Teenagers may also believe that contraceptives cause infertility and watery discharge. Contraceptive pills were only taken when they planned sexual intercourse or after engagement. Moreover, participants had no knowledge about emergency contraceptives (Mlambo, 2005:65).

2.9 Quality Reproductive Health Care Delivery

A consensus exists that good quality health care requires the presence of trained personnel, in well equipped clinics, where clients are treated courteously and provided with a variety of appropriate services. The term quality refers both to readiness or level of preparedness of facilities to offer services and the manner in which clients are cared for (Jain, 2001:222), RamaRao & Mohanan, 2003:228). The services rendered by providers need to be appropriate,
comprehensive and effective. For adolescent youth these have to be accessible, acceptable and equitable (WHO, 2004).

Quality improvement is an ongoing process as it cannot be achieved through a one off action or training, but should be done on an ongoing basis, as part of the staff teams general work cycle, and based on the assumption that quality can always be improved (Youth Friendly Services Manual, 2005).

A quality improvement initiative requires a team approach and cannot succeed through the efforts of an individual alone. Quality assurance is evidence based and uses local data to identify local problems and is comprehensive. Quality assurance includes structure, process and outcome (WHO, 2004).

Diagnostic studies in a variety of programme settings have identified constraints to good quality. These include deficiencies in physical facilities and equipment, disruptions in supplies, insufficient information provided to clients’ providers and insensitivity to the feelings and needs of clients. Finally, improvement in quality is hypothesized as a greater client satisfaction and understanding, and in the longer term, extended practice of contraception and avoidance of unwanted pregnancies. Assessment of satisfaction with reproductive health services by adolescents is also used as a strategy to measure quality of care with the aim of improving adolescent reproductive health care at public health facilities. (RamaRao et al, 2003:229).

Becker, Koenig, Kim, Cardona and Soenestein (2007, 206:206) argue that despite the importance and frequency of use of family planning services, and a vast literature on accessibility of services, relatively little is known about their quality. It is important for the family planning field to learn whether quality problems exist and, if so, develop strategies to address them. Learning more about family planning service quality is important for ethical reasons, as receiving high-quality care is a basic right of patients. In addition, one of the main motivators behind this area of research is the notion that family planning service quality influences contraceptive and reproductive health outcomes. Studies in diverse international settings, where family planning service quality has long been an area of intense focus for research and intervention activity, have linked service quality to contraceptive adoption,
prevalence and continuation. If services are not of high quality, clients may not receive the information and learn the skills they need to adopt and sustain successful contraceptive behaviour.

2.10 Initiatives to Improve Quality of Adolescent Reproductive Health Services

The elements which are important in improving quality of care rendered to adolescent reproductive health services were discussed:

**Availability**- For a service to be truly available, a number of conditions must be met, including easily accessible distribution points, where the supplies are consistent, staff are properly trained, and opening hours are convenient for clients. A key aspect of availability discussed at length is affordability, both for the service provider and for the consumer. Some countries have no control over the manufacture and supply of fertility regulation products, and this affects availability (WHO, 1998).

**Acceptability**- Acceptance and acceptability are influenced by many factors. For example, if health service providers judge one method better than another, then the counselling and information they provide is likely to reflect that bias and affect acceptance and use of that method. Similarly, policy-makers and providers may make incorrect assumptions about what is acceptable to women and men. Women’s definitions of acceptability change over time with changes in their circumstances. As they become more concerned with their rights and have more knowledge of their bodies, they may be less willing to accept methods that can adversely affect their health. Acceptability is also conditioned by the availability of methods. If only one or two methods are available, it is not meaningful to speak of acceptability because there is no choice (WHO, 1998).

According to (Haile et al, 2000:18), use of outreach programs would be appropriate especially for rural Africa because they are culturally acceptable as they involve the community in the design and implementation of the programs. In Zimbabwe, over 20% of modern family planning clients are served by community-based development agents and, in Mali, the government has introduced community-based development in almost 2000 villages with significant impact on the overall contraceptive prevalence.
Accessibility- Services are accessible when no geographic, economic, administrative, cognitive or psychosocial barriers prevent clients from obtaining them. In a study conducted in Peru, on women members of managed care plans in five states, 13% of those in commercial plans and 7% of those in Medicaid plans reported waiting four weeks or longer for a family planning appointment. Additionally, inconvenient hours of operation and difficulties reaching providers by phone have been noted as problems, especially for clients seen at subsidized clinics and hospitals (Becker et al, 2007:208).

Selecting the Contraceptive Method- Scientists want to ensure that the method they develop causes no dangerous or permanent side effects. The women who use contraceptive methods are also concerned about how these methods might affect their overall health, including their sexual interest, physical stamina, or emotional well-being aspects of health that have been given lower priority by researchers and service providers. Side effects such as menstrual bleeding disturbances, can be of extreme concern to women, and may affect how they perceive the safety of any method. What is known medically about safety of a method should be more adequately conveyed to women. For instance, a once-a-month injectable contraceptive sold over the counter in Latin American countries have been very popular among women because bleeding remains regular. However, the drug contains a high dose of estrogen which increases the risk of metabolic and cardiovascular diseases, a long term problem which is not noticed on a daily basis by the user (Becker et al, 2007:208).

Scientists measure the efficacy of a method by quantifying how often it fails to prevent pregnancy. The measures applied are rates of method failure and of user failure. Women, however, may define efficacy by how well a method works for them in their lives. Their measures include not only pregnancy prevention, but also satisfaction. The latter may encompass the effects the method has on the woman’s health relationship, her sense of control over the method, the freedom to use it when she pleases, and its efficacy to prevent infection (WHO, 1998).
Choice of Methods- According to a study conducted by (Bessinger & Bertrand, 2001:5-6) as cited in Becker and others, providers should ask new clients about their fertility intentions and assist them to select the most appropriate family planning method. Observers noted whether the provider and client discussed her desire for more children or the timing of next birth, staff conducting exit interviews asked each woman if the provider asked her whether she would like to have more children. In each country, results from observations and exit interviews were comparable (53% and 63% in Ecuador, for example). In Ecuador and Uganda, the proportion of women who stated during exit interviews that they received their preferred method (84% and 81%, respectively) was slightly higher than the proportion recorded during observations (80% and 76%, respectively). In studies asking clients directly about the method of choice available to them, few clients reported being unable to obtain their method of choice from the provider. Nevertheless, one-third of a nationally representative sample of black women reported that a family planning provider had strongly encouraged them to adopt a specific birth control method when they had wanted to use another one (Becker et al, 2007:209).

Communication and Information- Studies asking clients about specific information provided during the visit generally have found high proportions reporting discussions about specific topics, such as the effectiveness of different contraceptives and how to use particular methods. However, studies that have asked the clients to rate the quality of the information provision overall have tended to find less positive results. Fourteen percent of women in Washington felt that their family planning provider had not given them sufficient explanations at their most recent visit, among women seen at hospitals, the proportion reporting incomplete explanation was 25% (Becker et al, 2007:208).

Client-staff interactions- Across studies, women have generally reported respectful and friendly treatment by providers. However, few studies have distinguished clinicians and other staff members’ interaction with clients. Another aspect of client-staff interactions that has been studied is privacy, some studies have identified problems with privacy, especially while clients are waiting to be seen for their appointment (Becker et al, 2007:208).
**Efficiency and Effective Organization of Care** - The most widely studied aspect of this domain is the time clients spend in the waiting room. Time waiting to be seen is one of the indicators of quality consistently rated most poorly. Indicators of the organization of care such as the follow-up mechanisms in place to track clients over time and whether clients can be seen by the same provider at all visits have also been rated low. In the national study of directors of publicly funded family planning agencies, only 53% reported that their agencies had any mechanism in place to contact clients who missed appointments (Becker et al, 2007:208).

**Structure and Facilities** - Aspects of the physical structure studied have included crowdedness, cleanliness, noise level and overall organization. Physical features of facilities (particularly, the crowdedness and comfortableness of waiting rooms) have tended to be rated low (Becker et al, 2007:208-209).

Most studies have also cited various factors affecting health seeking behaviour amongst adolescent youth, namely: individual characteristics, community characteristics including cultural norms, cost, inconvenient hours and transportation problems and negative experience at a health facility (Ahmed, 1990:11).

In spite of these challenges, service providers increasingly recognize some obligation to provide sexually active people with preventive and curative reproductive health services, although they might be young and unmarried. Negative staff attitudes are often cited as the main reasons young people avoid seeking clinical services. To help in overcoming such resistance, many researchers believe that projects need to select staff members who are supportive of providing reproductive health to young people and to ensure training of the staff members. It has been cited that good interpersonal relationships should be the hallmark of an adolescent friendly service. Health care providers would be expected to show adolescent respect, and be able to engage them and win their confidence and respect (Laack, Carberg & Berggren, 1997:23).
Other approaches for increasing service utilization by adolescents have been cited by researchers namely: linking schools to health facilities, that if a large proportion of adolescents attend school, there is the potential to reach a large audience using this approach (WHO, 2000d).

Community mobilization is one of the approaches that will encourage increase in reproductive utilization by young people. There is preliminary evidence from Zambia that adolescents are more likely to utilize reproductive health services in communities that are more accepting of such services (WHO, 1998b). Consulting and involving parents and other influential members of the community may foster an environment which legitimizes the adolescent’s right to access sexual and reproductive services. These findings are in line with the importance family and socializing processes that promote health (Elliot, 1993:20).

Peer programmes that train young people to take health messages or health products to other young people of similar age and background have come to be a hallmark of an adolescent service (Senderowitz, 2000:14). Peer programmes stimulate a demand for service, perhaps through enhancing linkages to parents, families and communities (WHO, 2000d).

2.11 Legislation and Health Policy on Adolescent Access to Contraceptive Services

The National Contraception Policy Guidelines (1996:14) state that there is national commitment to upholding sexual and reproductive rights and access to reproductive health care.

The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996) enshrines reproductive rights and the right of access to reproductive health care. It states that everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction.

The Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996) promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs. Contraception is regarded as an integral part of Termination of pregnancy care (National Contraception Policy Guidelines, 1996:15).
The Policy Guidelines for Adolescent and Youth Health, 2009:40) stated that the National Department of Health includes sexual and reproductive health among its six top health priorities for adolescents and youth. Key intervention strategies that relate to contraception include promoting delayed child bearing, promoting marriage preparedness, facilitating easy, cheap and private access to all forms of contraception (including emergency contraception and condoms), using multimedia methods to provide information to adolescents, youth and their families about all sexual health matters, building skills specifically relevant for sexual health such as negotiating contraceptive use, providing sexuality counselling, and integrating sexual and reproductive health services.

The Essential Drugs List (EDL) for Primary Health Care (1998) specifies under the Family Planning section those contraceptive methods that should be available at each service level in the public sector, together with their recommended doses and method of availability (National Contraception Policy Guidelines, 1996:17).

In South Africa policies and programmes have been developed to address the problems and challenges facing the youth. The rapid spread of the HIV epidemic, especially amongst adolescents, has also meant that programmes have to focus their attention on interventions that aim to develop awareness and influence positive behavioural change among adolescents. Such interventions include media campaigns, life skills, and peer group education. The national youth commission was established in June 1996 by the former President Mandela to develop a comprehensive strategy to address the problems and challenges facing the youth in South Africa (Policy Guidelines for Youth & Adolescent Health, 2009:39).

According to the South African National Contraceptive Guidelines (2003:19) ‘the goal of a reproductive health framework is to improve the sexual and reproductive health of all people in South Africa and the purpose is to enable all people to exercise their contraceptive choice safely and freely”. The guiding principles include respect for, and promotion of human and reproductive rights for each client seeking contraceptive services. Contraceptives should be made available to all that need those, including adolescents, men, and people with disabilities and special needs. Contraceptive services should be free in the public sector. No client requesting a contraceptive of choice, not available at the clinic, should be sent away without being offered a safe and available method. An enabling legislative environment for the provision of contraceptive services should be created. Contraceptive methods should be
provided as part of comprehensive reproductive health. Despite all efforts to make contraceptives available to youth, it has however, been observed that the majority of adolescents do not have access to sexual reproductive health services.

2.12 Characteristics of Youth Friendly Services

Barriers to access of reproductive health services have been identified and the need to provide quality reproductive health services has been articulated. Many of these barriers can be addressed by initiating special programmes that take care of young people’s reproductive health needs. Sendorwitz (1999:14) stated that facilities are youth friendly if they have policies that attract youth to the facility or programme, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their youth clients for follow up and repeat visits. Providers” characteristics, health facility characteristics, programme design characteristics, and other possible characteristics of youth friendly services, have been delineated by Sendorwitz (1999:14) and AYA/Pathfinders International (2003) as the main features of an adolescent friendly programme.

2.12.1 Providers Characteristics

Adolescent health programme should include the following features: staff must be specially trained to work with young adults and should be trained to respect young people and their needs. They should acknowledge the central importance to adolescent privacy and confidentiality and clinic managers must allow extra time for counsellors, or professional health practitioners, to discuss young people’s special needs (Senderowitz, Hainsworth & Solter 2003:51).

2.12.2 Health Facility Characteristics

Separate space or special times should be set aside for young adult clients. Clinics should be opened at times convenient for young adults to attend, such as late afternoons, evenings and weekends. Facilities should be conveniently located. There should be adequate space arranged such that privacy is protected (Senderowitz et al, 2003:51).
2.12.3 Programme Design Characteristics

Audio-visual and print material dealing with issues relevant to young people should be offered in waiting areas. Overcrowding is avoided and waiting times are short. Boys and young men should be encouraged to attend, and special male services offered. Service charges should be low so that young people can afford them. Peer counselors should work with clients. Informal and formal group discussions should be held. The health facility offers a wide range of reproductive health services such as STI and HIV prevention, STI diagnosis and treatment, nutritional services, sexual abuse counselling, prenatal and post natal care and abortion services (Senderowitz et. al, 2003:52).

Serving young people with reproductive health care is still a sensitive issue in many places. Attitudes of some service providers reflect negativity in addressing adolescent reproductive needs. Availability of policy guidelines addressing the needs of adolescent youth, strong institutional commitment, careful staff selection and training and re-allocation of funds are essential components of youth friendly services (Senderowitz, 2003:52).

2.12.4 Other Possible Characteristics

Reading material should be available for use by clients while they are waiting, computer based health education programmes are used in some clinics. Group discussion, alternative ways to access information, counselling and services, delay of pelvic assessment and blood tests, are strategies that must be used to improve service delivery at the primary health facilities (AYA/Pathfinder, 2003).
2.13 Study Designs, Data Collection Methods, and Programmes used to assess Quality of Service Delivery

Different assessment methods and tools have been used in previous research studies. Tools that were used appear to be valid and reliable, in that the variables and concepts used were able to produce the same results from different research studies. The questionnaires which the researcher studied, have attempted to successfully answer the stated research questions. The following paragraphs will look at summarized research methods and approaches used by researchers in the collection of data, for example, focus-group interviews that were conducted with teenage client’s participants, selected randomly, covering information sources on sexuality and availability of contraceptives and the desirability of providing separate family planning services for youth (Mfono, 1998:32).

Semi-structured interviews and 5 focus groups, each containing 3-6 informants were conducted with Pedi adolescent women who were recruited from clinic waiting rooms and schools (Wood, Maepa& Jewkes, 1998:26).

In a study conducted by Nare, Katz and Tolley (1997:32), two focus groups discussions were organized with a total of 17 female and 2 male teenagers, and from these participants, 10 female and 2 male teenagers volunteered to be mystery clients. The use of exit interviews, quality assessment tools, and rapid assessment of Youth Friendly Reproductive Health Services will be dealt with in the following section.

In another study conducted by Mlambo (2005:62) on perceptions of teenagers in the Bushbuckridge district on teenage pregnancy, an explorative, descriptive and qualitative design was followed. Data was collected by conducting a face-face interview with each participant. The study population involved teenagers from the ages of thirteen to the age of nineteen in the Bushbuckridge district who attended an antenatal clinic, a family planning clinic, were admitted in a postnatal ward. A convenient sampling technique was used. Teenagers who were available at the four sample sites and willing to participate were included. Thirty-two teenagers were selected that is 22 girls and 10 boys.
2.14 Use of Observations and Exit Interviews for Measuring Quality of Reproductive Health Services

In a study, Monitoring Quality of Care in Family Planning Programs, conducted by Bessinger et al (2001:3), a comparison of observation and client exit interviews were used. The quick Investigation of Quality (QIQ) was developed to monitor quality of care by using observations of client-provider interactions, exit interviews with clients and facility audits. The QIQ was field-tested in multiple countries in 1998-1999. Using linked data for 583 clients in Ecuador, 539 in Uganda and 736 in Zimbabwe, this analysis the comparability of results from observations and exit interviews. Results of this study were as follows: for a given indicator, levels of agreement between data from observations and interviews varied across countries, but within a country, results were consistent between instruments. For the three countries combined, agreement was good to excellent on the 13 of the 14 indicators examined, observations and exit interviews yielded consistent responses in 63-99% of cases. Agreement was highest on the indicators that measured interpersonal relations. Inconsistencies reflected primarily that clients received information outside of the observed client-provider interaction.

Both methods have limitations. The reliability of data from observation can be an issue because observers may interpret the same set of provider actions differently. Observation also introduces the potential bias that service providers will perform better than they might under usual circumstances. Observations of client-provider interactions is also limited in that it includes only a part of the clients visit and does not cover, for example, group counselling sessions, where clients may receive important information. Moreover, this type of data collection requires more skilled personnel than a standard interview, since the observer must have adequate clinical background to judge whether procedures are performed correctly. The researcher must also be quick enough to record a series of events that often do not occur in the same order as they are listed on the data collection form (Bessinger et. al, 2001:3).

Exit interviews have their own set of problems, the most serious of which is courtesy bias. Respondents may give what they consider socially acceptable answers, especially if they believe that the interviewer works for the clinic or that unfavourable comments could negatively affect the services they will receive in future. In addition, clients may have such low expectations of services that even when the quality of services is poor, it exceeds their expectations and they report positively on their experience. One would expect that indicators
measuring subjective states such as attitude, opinions or feelings would be more susceptible to courtesy bias than more objective measures. It is possible, however, that providers were on their best behaviour because of the observer’s presence, and clients were truthfully reporting good interpersonal relations. A further concern is recall bias, which occurs when a respondent cannot accurately recount what happened during the session. Recall bias may account for a clients’ “forgetting” that specific or particular information was provided during the visit. Given that the client was interviewed immediately following the visit, she may not have had time to think about the session and process all of the information that she received (Bessinger et al, 2001: 3).

Client exit interviews are designed for clients on leaving a clinic after using its services and are used to capture perception of the quality of care. In a study conducted in Peru by Santillan and Figueora in 2001 as cited in Sendorwitz (2000:23), client exit interviews conducted at the clinic were followed by interviews conducted at client’s homes within a week after a visit to a clinic, to allow clients to elaborate without clinic staff nearby (Senderowitz,2000:23).

2.15 A Rapid Assessment of Quality Reproductive Health Services

Young people face greater reproductive health risks than adults due to lack of awareness, inadequate information and significant barriers posed by the current state of most reproductive health services that are perceived as unwelcoming (Sendorwitz et al, 2003:56).

In order to take steps towards improvement of reproductive health services, a tool for rapid assessment of quality reproductive health services was developed by Sendorwitz et al (2003) to facilitate the rapid assessment of services provided for the youth in health facilities. Among the key issues assessed, were provider attitudes, privacy and confidentiality, supportive policies, and administrative procedures. The aim of development of this tool was to provide the basis for development and implementing of programmes that would attract adolescents to reproductive health services. This tool was designed to fit various methods (including provider and client interviews, observations) and could be used to establish a baseline survey, prepare improvement, and measure changes in quality by conducting post-test interviews, also allowing for management and staff to become more involved in programmes established to
obtain input from adolescent clients. This tool was also developed to assess youth friendliness, in order to develop an action plan to make services more attractive and responsive to youth reproductive needs and to create an appropriate training plan for upgrading staff skills with respect to providing quality reproductive health services (Sendrowitz et al, 2003:54).

2.16 Strengths and Weaknesses of some Research Studies

Strengths, weaknesses and limitations have been acknowledged in the review of literature. Most of the researchers used more than one method of data collection, an approach that was beneficial in strengthening the validity of the results. Weaknesses affecting some of the studies are related to issues around sampling methods, lack of recognition of participants ethical and human rights issues and failures to screen for age in some instances.

Becker et al (2007:9) argue that, despite the importance and frequency of use of family planning services, and a vast literature on accessibility of services, relatively little is known about their quality. It is important for the family planning field to learn whether quality problems exist and, if so, to develop strategies to address them. Learning more about family planning service quality is important for ethical reasons, as receiving high-quality care is a basic right of patients. If services are not of high quality, clients may not receive the information and learn the skills they need to adopt and sustain successful contraceptive behaviour. One of the important strengths of the available research is that it has conceptualized quality as a multidimensional construct. This trend should be continued, as theory on service quality suggests this is an appropriate conceptualization. However, a weakness of the literature has been a lack of consistency in the domains of quality studies. An important step is for future studies to be guided by more explicit definitions of quality and by conceptual frameworks delineating its domains. This will lead to greater consistency in the domains studied and will allow for better assessment of trends. A further important issue to address is what dose of a high-quality service is necessary to make a difference for clients. One visit to a high-quality service provider is unlikely to have a lasting effect on clients, and this may help explain the lack of effects seen in some of the previous quasi-experimental and experimental studies on quality. It may be more reasonable to assume and assess the likelihood that multiple doses of high-quality services are required to have an impact on client behaviour.
CHAPTER THREE – METHODOLOGY

3.1 STUDY DESIGN

A quantitative descriptive study was conducted over four weeks covering the eleven primary health care clinics in Mdantsane township in the Eastern Cape Province.

3.2 STUDY SETTING

The study was based on the population of adolescents between the ages of 19-24 years old, residing in Mdantsane in the Eastern Cape Province, South Africa.

Mdantsane Township has eleven clinics and is the most densely populated of the East London Local Service Area, consisting of an estimated 545 093 citizens of whom adolescents between the ages of 19 to 24 years are estimated at 12 523 individuals (Buffalo City Local Service Area sub-district mid-year 2009 health statistics (Unpublished report). Mdantsane is composed of 17 zones or units with eleven clinics.

3.3 SELECTION OF STUDY SITES

All the 11 Mdantsane clinics were selected for the research study in order to obtain a suitably large sample as attendance at these clinics is high. The desired sample size was 110 participants though only 73 respondents filled in the questionnaires because some of the respondents who answered the questionnaire were below age 19 and others above 24 years, and these responses were nullified as the selected age group was 19 to 24 years. Only one respondent responded from NU-8 clinic and only 4 responses were obtained from NU-17 clinic. Professional nurses at NU-17 clinic reported that adolescents at this clinic do not utilize the health services most frequently; they consult private doctors using their parent’s medical aids. This situation resulted in the researcher visiting these 2 clinics 3 times to obtain the required number of respondents. Most adolescents utilize NU-9 clinic because they are attending school at this unit.
3.4 Study Population, Sample and Sampling Procedure

The study population comprised of adolescents, male and female between 19-24 years of age residing at Mdantsane attending family planning services at the Mdantsane clinics. Adolescents were chosen because they are the most vulnerable group to coercive sex and peer group pressure to conform to certain sexual practices. A convenient sample of 110 respondents between 19-24 years of age was selected for this study, though only 73 respondents filled in the questionnaires. This number was based on the number of adolescent clinic attendees appearing in the family planning register which is approximately 50 per clinic in one month. The first 10 respondents attending the family planning clinic were selected from each of the eleven clinics. Adolescents who had given consent to participate, demonstrated an interest and understanding about the study and the informed consent process were included. Respondents who did not fit into these criteria were excluded.

3.5 The Instrument (Questionnaire)

A self administered questionnaire with 24 questions was used in this study and was divided into six sections as follows:

Section A consisted of demographic data covering age of the respondents, their marital status and previous pregnancies. Section B required responses on health facility amenities, such as private consulting rooms, adequate space, cleanliness, convenient hours and Bathopele Principles (principles ensuring that clients receive a service of high quality). Section C required responses on accessibility including affordability and information services. Section D required responses on staff characteristics, such as staff friendliness, understandable language use, attention to problems experienced by clients, choices made to see male family planning health worker, seeing service provider with a partner, full disclosure of information about availability of contraceptives and necessary referrals. Section E covered the availability of sexual and reproductive health services such as emergency contraception, peer counsellors, pap smears and the availability of contraceptives. Section F required responses on educational material such as posters, health education on side-effects, and the availability of family planning audio-visual material. The last question required a comment on the quality of standards in these clinics.
3.6 VALIDITY AND RELIABILITY

3.6.1 VALIDITY

Kumar (2005:153) defines the term validity as the ability of an instrument to measure what it is designed to measure. A pilot study was thus conducted to check if the questionnaire would give valid answers. Pre-testing of the instrument was done on 10 respondents residing at Scenery Park Clinic. These respondents were not included in the study sample. The questionnaire provided an adequate representative sample of all content or elements of the phenomenon being measured. All items used in the questionnaire went through some form of validation, by checking the questionnaire for correct interpretation of the English language to Isixhosa which was undertaken by a Xhosa language expert.

3.6.2 RELIABILITY

Kumar (2005:156) defines the concept of reliability as the consistency, stability, predictability and accuracy of the research instrument. The questionnaire used repeatedly must give constant similar results. A pilot study was conducted and it gave the same results as with other questionnaires used in similar studies.

3.7 Method of data collection

After consultation for the reproductive service, respondents were welcomed to a reserved waiting room, request for permission to conduct the study was read to them as individuals, and they were allowed to read the permission letter. After signing the consent form and verbally agreeing to participate, they were given the questionnaires to complete.

Data collection was conducted from 20 July to 21 August at all the eleven primary health clinics in Mdantsane. A face- to- face structured questionnaire, requiring the participant to answer “yes” if she or he agrees with the statement or “no” if one does not agree was used. After receiving the service, the respondent was asked to come to a private room. The request for permission to conduct the study was initially read, and the participant was also allowed to read the permission letter. After signing the consent form and verbally agreeing to participate, the respondent was given a questionnaire. The informed consent was kept separately from the questionnaire to ensure confidentiality. Instructions were clearly explained. Completed
questionnaires were collected and names of the respondents were not required, thus confidentiality was strictly maintained throughout data collection.

3.8 Method of data analysis

All questionnaires were examined by the researcher and carefully examined again prior to data entry. Data errors, such as wrong spelling, were corrected immediately at the clinic before the participant left. Data was then entered on a laptop using Microsoft Excel.

The initial data analysis was conducted by the author of this research study. Data were entered on a spreadsheet according to variables. Microsoft Excel 2007 Version 6 was used to analyze data. Data were presented in tables and graphs. ‘Yes’ and ‘no’ responses for each variable were counted and also converted to a percentage and presented in graphs. The demographic data of the participants was also presented in a graph form (age of participants) and others (marital status, state of previous pregnancy) was illustrated in tables.

3.9 ETHICAL CONSIDERATION

Permission to conduct the study was obtained from the University of Fort Hare Ethics Committee. Clients were requested to participate on a volunteer basis and further explanation regarding the aims and benefits of the study was given. The request to conduct the research at the 11 Mdantsane clinics was sought from the Department of Health Ethics Committee, Bhisho. Clinics were informed timeously of the intention to conduct the study using adolescent youth as participants.

The contents of the informed consent document and the questionnaire were read out loud before the participants were allowed to sign the consent form. The researcher verified that the participants were in agreement before signing the consent form and completion of questionnaires. The questionnaires were distributed to participants after obtaining signed consent forms. Privacy and confidentiality was ensured by using a consulting room not in use at the time. Anonymity was ensured by identifying the questionnaires by assigning numbers in the place of names of respondents.
3.10 Limitations of the study

The sample size was small. Secondly, the participants were not randomly selected for the study, and therefore findings may not be generalisable to the population of adolescents in 19-24 age groups living in the study area. However, the significance of this study is about identification of health, and social needs for quality improvement of reproductive health service delivery for adolescents at primary health care facilities.
4. CHAPTER FOUR – The Results

Section 1- Demographic characteristics.

Table 1 illustrates that out of 73 adolescents who utilized reproductive health services, 9.5% (n=7) were married, 79.5% (n=58) were not married and 11% (n=8) were living with a partner.

Table 1 Marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>No. N= 73</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>7</td>
<td>9.5%</td>
</tr>
<tr>
<td>Not married</td>
<td>58</td>
<td>79.5%</td>
</tr>
<tr>
<td>Living with a partner</td>
<td>8</td>
<td>11%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2 illustrates the percentage of adolescents who are less than 20 years utilizing these services is 23.3% (n=17) and the percentage of those who are between 20 and 24 years is 76.7% (n=56).

Table 2 Age distribution

<table>
<thead>
<tr>
<th>Age distribution</th>
<th>No</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20 years</td>
<td>17</td>
<td>23.2%</td>
</tr>
<tr>
<td>20-24</td>
<td>56</td>
<td>76.8%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 3 illustrates the percentage of adolescents who had previous pregnancies were 40% (n=29) while those with no previous pregnancies were 60% (n=44).

**Table 3 Previous pregnancy status**

<table>
<thead>
<tr>
<th>Previous pregnancy status</th>
<th>N0</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous pregnancies</td>
<td>29</td>
<td>40%</td>
</tr>
<tr>
<td>No previous pregnancies</td>
<td>44</td>
<td>60%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>73</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Section 2: Health facility amenities**

Figure 1 below shows adolescents ratings of quality regarding availability of private consulting rooms, adequate sufficient space, cleanliness of the environment, convenient hours and if Batho Pele principles are displayed. Out of 73 participants, 86% (n=63) indicated that private consulting rooms were available, and 14% (n=10) commented that there were not enough private consulting rooms in the clinics. Most of the adolescents, 82% (n=60) reported that the space in the clinic and consulting rooms is adequate while 18% (n=13) indicated that the space is inadequate. Most of the participants, 75% (n=55) reported that clinic environment was clean, while 25% (n=18) stated that the environment was not clean. Most of the respondents, 84% (n=61) indicated that the service is offered during convenient hours while 16% (n=12) reported that family planning hours were inconvenient for them. Some of the participants, 70% (n=51) stated that Batho Pele Principles were displayed and 30% (n=22) reported that these principles were not displayed.
Section 3: ACCESSIBILITY

Figure 2 below showed adolescents’ ratings of the quality regarding accessibility. Most of the respondents, 91% (n=66) indicated that the services were easy to access and a few, 9% (n=7) reported that services were not easy to access. Most of the participants, 92% (n=67) stated that services were affordable and 8% (n=6) indicated that the services were not affordable. Some of the adolescents, 60% (n=44) reported that information services were available and others 40% (n=29) stated that information services were not available.
Section 4: STAFF CHARACTERISTICS

Table 4 showed adolescents ratings of quality regarding staff characteristics.

<table>
<thead>
<tr>
<th>Staff Characteristics</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff friendly</td>
<td>54</td>
<td>74%</td>
</tr>
<tr>
<td>Explain everything</td>
<td>58</td>
<td>79%</td>
</tr>
<tr>
<td>Understandable language</td>
<td>70</td>
<td>96%</td>
</tr>
<tr>
<td>Attend to clients problems</td>
<td>47</td>
<td>64%</td>
</tr>
<tr>
<td>Choice to see male health worker</td>
<td>26</td>
<td>36%</td>
</tr>
<tr>
<td>See service provider with partner</td>
<td>44</td>
<td>60%</td>
</tr>
<tr>
<td>Full information about available contraceptives</td>
<td>43</td>
<td>59%</td>
</tr>
<tr>
<td>Necessary referral</td>
<td>14</td>
<td>19%</td>
</tr>
</tbody>
</table>
Section 5: Availability of Sexual and Reproductive Health Services

Figure 3 illustrates adolescents’ ratings regarding availability of sexual and reproductive health services. Out of 73 participants, 9% (n=7) reported that emergency contraception was available and 91% (n=66) stated that emergency contraception was not available. Few respondents, 22%, (n=16) indicated that peer counselors were available and 78% (n=57) stated that peer counselors were not available. Some of the adolescents, 19% (n=14) indicated that pap smears were available at the clinics and 81% (n=59) reported that pap smears were not available at the clinics. Most of the participants, 95% (n=69), stated that contraceptives were available at the clinics and 5% (n=4) reported that they were not always available.

Figure 3 Availability of Sexual and Reproductive Health Services
Section 6: Availability of Educational Material

Figure 4 shows availability of educational material at the clinics as rated by adolescents. Out of 73 adolescents, 74% (n=54) reported that posters educating about contraception were available at the clinics and 26% (n=19) indicated that there were no posters displayed. Some of the participants 51% (n=37) stated that they were given health education on side effects of contraceptives and 49% (n=36) indicated that they were not educated about the side effects. All of the respondents, 100% (n=73) reported that there were no audio-visual materials at the clinics.

Figure 4 Educational material
Section 7: Adolescents ratings of the Level of Quality of Reproductive Health Services

The table below presents adolescents ratings of the level of quality, 19, 2% (n=14) commented that reproductive health services were high, 72, 6% (n=53) reported that the services were moderate and 8, 2% (n=6) indicated that quality of services were low.

Table 5 Percentages rating level of quality of reproductive services

<table>
<thead>
<tr>
<th>Quality</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>14</td>
<td>19,2%</td>
</tr>
<tr>
<td>Moderate</td>
<td>53</td>
<td>72,6%</td>
</tr>
<tr>
<td>Low</td>
<td>6</td>
<td>8,2%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100</td>
</tr>
</tbody>
</table>
CHAPTER FIVE – DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 DISCUSSION

5.1.1 Clinic location and type

A total of 11 clinics were visited in this study. Only one participant was interviewed at NU-8 Clinic. Most of the adolescents staying at this unit receive their family planning services at NU-9 clinic in the afternoons because they attend school at that unit. NU-9 clinic had a high turnover of adolescents utilizing reproductive health services. NU-17 had a low turnover of adolescents, only 4 respondents were interviewed because adolescents staying at this unit apparently consult with private doctors for reproductive health services.

5.1.2 Respondents by age

Respondents between 19 to 24 years were selected for the study. Out of 73 participants, 23% (n=17) of the participants between 18, 5 to 19, 5 years was the largest group utilizing reproductive health services and 11% (n=8) of the participants between 24, 5 to 25, 5 was the smallest group utilizing reproductive health services. The researcher identified that adolescents between 19 to 24 years are more vulnerable to adolescent pregnancy. These findings support discussions from other studies. The adolescent pregnancy is high in South Africa, despite a relatively high reported contraceptive prevalence of 64.4% among 15 to 19 year old sexually active young women (Nicholas et al, 2009). Results from a research conducted by the South African Demographic and Health Survey (1998), revealed that teenage pregnancies commonly occur in women who are at school.

5.1.3 Marital status of the study population

Out of 73 participants, 9, 5% (n=7) were married, 79, 5% (n=58) were not married and 11% (n=8) were living with a partner. These findings are in line with data found in report from a survey by the Department of Health in 1999 (Department of Health, 1999). Secondary and post high-school students are at risk of acquiring STDs because they are mostly single and the highest incidence of infection occurs in people between ages of 15 and 24 (Nicholas et al, 2009:30).
5.1.4 Respondents by gender

Participants in this study were only female because they are the dominant group who visit reproductive health services. This shows that society experiences serious sexual orientation deficits and perceptions, that contraceptive and reproductive services are only the concerns of females. Health services traditionally have concentrated on women and the majority of health workers are females. It has been argued that young men benefit more when there is a male health professional they can talk to, question about their sexual development or their performance, as these issues cannot be discussed with anyone else (Laack et al, 1997:15).

5.1.5 Level of quality of reproductive services

This section is divided into five sections: health facility amenities, accessibility, and staff characteristics, availability of sexual and reproductive health services and availability of educational material. All responses discussed below yielded scores below 90%. Differences in scores obtained, indicate that levels of quality vary from being moderate to low.

5.1.6 Quality regarding health facility amenities

Results from this section indicated that adolescents were not satisfied with cleanliness in the clinics, complained of overcrowding. The variable “private consulting rooms” had low ratings; respondents complained that one consulting room is used by more than two nurses consulting more than one client. Under this section the highest score was 84% (n=61) representing convenient hours and the lowest score was 15% (n=18) indicating that the space in the clinics is not adequate. The researcher also can argue that primary health care facilities are not spacious enough to accommodate adolescents who have come for family planning services, at some clinics adolescents were standing outside. These results are consistent with those reported by Sendorwitz (1999) who stated that facilities are youth friendly if, they have policies that attract youth to the facility or programme, provide a comfortable and appropriate setting for serving youth.
5.1.7 Accessibility

Most of the respondents, 91% (n=66) indicated that the services were easy to access, 92% (n=67) stated that services were affordable. Some of the adolescents, 60% (n=44) reported that information services were available. The lowest score was 44% (n=29) indicating that information services were not available. These findings are supported by other researchers. Roux (2002) stated that when clients can easily obtain services, they are better able to use family planning and to obtain help when they want it. In the broadest sense, a population as good access to services when service delivery points are conveniently available to everyone, everyone knows where to find these services, everyone feels welcomed, services are free of unnecessary administrative and medical barriers, and people can choose from a range of contraceptives.

5.1.8 Staff characteristics

The variables” staff friendliness” 74% (n=54), “ use of understandable language” 96% (n=70) and” explanation of everything” 79% (n=58) yielded highest scores whilst the variable “necessary referral” 19% (n=14) yielded a lowest score. Negative attitudes of staff will hinder the use of reproductive services by adolescents. According to Knott and Lotter (1999:580) as cited in (Mlambo, 2005) teenagers are afraid to make use of family planning services, are dissatisfied with the quality of communication at the clinics, perceive staff as being unapproachable. They want health care providers to be approachable, friendly and caring.

5.1.9 Availability of sexual and reproductive health services

The variables “emergency contraception” 91% (n=66), “peer counsellors”78% (n=57) and” pap smear” 81% (n=59), yielded highest scores of “no responses” meaning that these services are not rendered at the clinics. Most of the respondents were not told about these services. The main characteristics of an adolescent health programme include the following features: staff must be specially trained to work with young adults, should be trained to respect young people and their needs, acknowledge the central importance to adolescent privacy and confidentiality
and clinic managers must allow extra time for counselors or professional health practitioners to discuss young people’s special needs (Senderowitz, 1999).

5.1.10 Availability of educational material

The highest score of ‘yes” responses regarding posters was 74% (n=54), education on side effects obtained 49% (n=36) of ‘no” responses and audio-visual material obtained 100% of ‘no’ responses. Lack of reproductive health education at the clinics was reported by the participants. This results in discontinuation of contraceptives, when one experiences some side effects and does not know what to do because she was not educated about the side effects. Reading material should be available for use by clients while they are waiting. Computer based health education programmes are used in some clinics in United States of America. Group discussion, alternative ways to access information, counselling and services, delay of pelvic assessment and blood tests, are strategies that must be used to improve service delivery at the primary health facilities (AYA/Pathfinder, 2003).

5.1.11 Respondents comments about levels of quality

Respondents who rated levels of quality as being high were 19, 2% (n=14), moderate 73% (n=53) and low 8, 2% (n=6). This means that most of the adolescents (n=53) are not satisfied about quality of reproductive health services.
5.2 CONCLUSIONS

According to the results of this study, adolescents were not satisfied with adolescent reproductive services at Mdantsane clinics. Judging from the relatively high scores obtained by individual participants in some instances, it became clear that some adolescents were not aware of their reproductive health rights, and could not detect whether the services they were receiving were within an accepted standard of care. This has been shown by increased positive responses where there was no evidence availability of such an item for example, for availability of posters’ there were 74% of “yes” responses, but 51% of “yes” responses regarding education on side effects’. A conclusion can be reached that the level of the quality of family planning services rendered to adolescents by health workers at Mdantsane clinics is moderate because 73% of the respondents indicated that the level of the quality in these clinics is moderate and 14% of the respondents reported that the level of quality is high.

The majority of the researchers reported that readiness of a facility to deliver a contraceptive service depends on readiness and the quality of care rendered there. Readiness refers to the factors such as infrastructure, contraceptive supplies, buildings, management information system, logistics, and the availability of trained staff (Nicholas et al, 2006:53).

Quality of care includes all the characteristics of client provider contact, including interaction with health personnel, not directly related to service provision. Finally, improvement in quality is hypothesized to result in clients’ greater satisfaction and understanding, and longer term effects such as extended practice of contraceptives and avoidance of unwanted pregnancies (WHO, 1999).
5.3 RECOMMENDATIONS

The results from this study suggest that there is a definite need for improvement of adolescent reproductive health services at Mdantsane clinics. It is clear that the current available maternal and child health programmes, school health services and reproductive health services are not able to meet the adolescent sexual and reproductive needs. Adolescents need a safe and supportive environment that offers information and skills to equip them on all aspects related to sexual and reproductive health issues.

The basic health services that must be provided for adolescents include reproductive health services, voluntary counselling and testing for HIV and STIs, rape and domestic violence. Health workers need to be friendly and also capacitated with knowledge and skills, assisting health workers to render adolescent services that are of high quality. Aspects of quality improvement could be best achieved by those health professionals working at the clinics, with support from management, availability of infrastructure including equipment which supports service provision and an ongoing process requiring a team approach.

Policies and programmes that have been developed to address problems and challenges facing the youth in South Africa should be implemented accordingly, focusing on interventions that will raise awareness and influence positive behaviour change among adolescents (National Adolescent Friendly Clinic Initiative report, 2003).

To avoid issues of courtesy bias, the need to conduct a similar survey utilizing alternative community services, namely homes of participants or a school based survey is necessary. A follow up visit that would take place after the exit interviews at the homes of participants, could have been conducted to control possible courtesy bias occurring in the exit interviews.

According to Williams et al (2000), client satisfaction interviews should always be considered to be just one part of a quality evaluation approach. The use of other quality evaluation instruments, such as provider surveys, review of clients’ records or focus groups could be used in conjunction with client exit interviews monitoring the quality of reproductive health services. Client exit interviews are powerful instruments for measuring some aspects of client satisfaction with reproductive health services, and serve as suitable tools for assessment of quality service delivery, to improve reproductive health delivery services for adolescents.
Surveys conducted for measuring adolescent satisfaction and their opinions about the quality of reproductive services are one of the essential methods that must be implemented to establish a baseline, to prepare a plan for improvement of facility service delivery.
REFERENCES


Cape Town, Department of psychiatry, University of Cape Town.


Available from http://www.fao.org/sd/wp direct/WP an 0044.htm retrieved on 07.07.10


Statistics South Africa. Pretoria.


Available from http:/www.uneca.org/eca resources/major retrieved on 20.07.10


Application for clearance from the University of Fort Hare’s Ethics Committee

Project Title: An assessment of the quality of family planning services rendered to adolescents by health workers at Mdantsane Clinics, Eastern Cape Province, South Africa.

Chief Researcher: Siphokazi Ndlebe

Supervisor/co-supervisor: Mrs B.F. Mayeye
                      Prof C Rautenbach

Date of application: 29 May 2009

Having consulted the Dean of Research, I hereby grant permission to conduct the research.

Professor J R Midgley
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee
6 April 2009
Dear Ms S Ndlebe

Re: A descriptive study of the assessment of the quality of family planning services rendered by health workers to adolescents at Mdantsane clinics, Eastern Cape Province

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants. You will not impose or force individuals or possible research participants to participate in you study. Research participants have a right to withdraw anytime they want to.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

ZIM
DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT
To: Clinic Supervisors (Mdantsane PHC)

Subject: Re: A descriptive study of the assessment of the quality of family planning services rendered by health workers to adolescents of Mdantsane clinics, Eastern Cape Province.

I.S Ndlebe is a second year Master in advanced community student at the University of Fort Hare. She would like to do the above mentioned research in your institution. The Buffalo City LSA manager has approved this research. Mdantsane PHC is requested to give her all sources of information she may need in this research. An approval letter from the Province is attached.

Your co-operation will be highly appreciated in this regard.

Yours faithfully

Mr. T.T Zamxaka
Buffalo City Sub-District Manager

Date: 11-08-2009
CONSENT FORM

This is a study of the Assessment of quality of family planning services rendered to adolescents by health workers at Mdantsane clinics[NU-1,3,5,7,8,9,12,13,16,17 and Potsdam]. I am a post graduate student at University of Fort Hare and this study is a requirement for Masters degree in nursing.

It will be done in the form of a questionnaire and you are requested to answer all questions truthfully. Your name will be used for purposes of informed consent, will be kept in confidentiality and anonymity, it will not be revealed in the report on completion of the study.

Your signature at the bottom of the page will be appreciated as proof that you were informed of procedures involved in the study and have agreed to participate voluntarily.

I....................................agree to participate in the study conducted by Siphokazi Ndlebe, she has explained all the procedures involved in details and has ensured confidentiality and anonymity.

Signature......................

Date …………………...

Researcher....................

Date…………………..
QUESTIONNAIRE FOR ADOLESCENTS PARTICIPATING IN THE STUDY OF ASSESSING QUALITY OF FAMILY PLANNING SERVICES RENDERED TO ADOLESCENTS BY HEALTH WORKERS AT MDANTSANE CLINICS

Please Note: The attached questionnaire forms part of research project on assessment of quality of family planning services rendered by health workers at Mdantsane clinics. You are not requested to furnish your name, please answer all questions honestly.

IDENTIFICATION SITE …………………… DATE ………………………

- For each of the following statement, kindly indicate your answer by ticking in the appropriate box:

A. DEMOGRAPHIC DATA

1. AGE………………………..YEARS
2. MARITAL STATUS

☐ I am married

☐ I am not married

☐ I am living with my partner

3. Do you have any previous pregnancies?..............................
B. QUESTIONS

- **Health Facility Amenities**

  1. Private consulting rooms are available
     -  
  2. Adequate and sufficient space is available
     -  
  3. The environment is clean
     -  
  4. Service is rendered during convenient hours for clients

     Please explain.................................

  5. Bathopele principles are displayed
     -  

- **Accessibility**

  6. The services are easy to get to
     -  

How far is the clinic from where you stay? Please explain ......................

  7. The service is affordable for young people
     -  

     Do you pay for family planning services?

  8. Information is available about services offered
     -  

     Were you given information about family planning services offered?

     Please explain.................................
• Staff characteristics

9. Staff is friendly

   How are you welcomed? Please explain............... 

10. Staff answer all questions to your satisfaction

   Please explain your own experiences......................

11. Staff use understandable language

12. Staff attend to problems expressed by clients

   Please give examples from your own experience.............

13. Choice made to see either male or female health worker

14. Choice made to see service provider with your partner

15. Full information given about available contraceptives

   Did you choose the contraceptive you are using?

16. Necessary referral is made

   Have you encountered any reproductive health problem? If, yes were you referred?

• Availability of sexual and reproductive health services
17. Emergency contraception is available

Were you told about emergency contraception?

18. Peer counsellors available

19. Pap smears done

When were you last done Pap smear? ....................

20. Availability of contraceptives, condoms

Do you always get your contraceptives?

Please explain..............................................

- **Educational Material**

21. Posters on different family planning methods displayed

22. Health education on family planning methods, side effects

Do you get full education about family planning methods?

Please explain..............................................

23. Availability of family planning audio visual material

Is information about family planning conveyed through television and
24. What else can you say about quality of family planning services rendered at your clinic?

THANK YOU FOR ANSWERING ALL THE QUESTIONS